IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

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Case No. 2:20-cv-6256

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James A. Burk, Jr., et al.,

Plaintiffs,

vs.

City of Columbus, et al.,

Defendants.

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Deposition of: LARAE COPLEY, M.D.
Date and Time: Friday, September 27, 2024
8:51 a.m.

Place: Columbus City Attorney's Office
77 North Front Street
4th Floor
Columbus, Ohio 43215

Stenographic
Reporter: Carla D. Manahan, RPR,
Notary Public - State of Ohio

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APPEARANCES:

On behalf of Plaintiffs:
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On behalf of Defendants:

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Friday Morning Session,
September 27, 2024.

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LARAE COPLEY, M.D.
being by me first duly sworn, deposes and says as follows:

EXAMINATION

BY MS. CHIN:

Q. Good morning, Doctor. Is it Copely?
A. It's Copley.
Q. My name is Abby Chin. I represent the plaintiffs in this matter. Could you start by stating your name and spelling it for the record?
A. Sure. It's LaRae, L-A-R-A-E, Copley, C-O-P-L-E-Y.
Q. And what's your business address?
A. So my business is actually 6193 Rings Road. I have a PO box there. I work out of the home.
Q. And you understand that you're under oath today from the oath that the court reporter just gave.
A. I do.
Q. Have you had your deposition taken before?

A. No.
Q. All right. So I'm going to start by going over a few ground rules. I'm sure your attorneys prepped you but just so we're on the same page moving forward.
A. Sure.
Q. The court reporter is taking down everything that we're saying today. So I just ask that you provide verbal answers to my questions rather than head nods or shakes or uh-huh, huh-uh so we have the same record, same page.
A. I will try.
Q. I will do my best not to interrupt you. I ask that you do the same with me just so, you know, I ask my full question. I'll try to let you answer fully before we move on. Is that fair?
A. It is.
Q. I may occasionally ask a bad question. If you don't understand the question that I'm asking, please ask me to clarify. Okay?
A. Okay.
Q. If you answer the question, I'll assume that you understood it. Fair?
A. Fair.
Q. You were hired by the City of Columbus

and some of the police officers in this case?
A. I was hired by the City of Columbus, yeah.
Q. Okay. I'm going to hand you what I've had marked as Copley 1. If you want to take a look at this exhibit --
A. Uh-huh.
Q. -- and let me know if you've seen it before.
A. I have. It's my typical contract for services.
Q. Okay. And do you have a signed copy of this?
A. I do.
Q. Okay. Is there any reason that this copy would be different than the signed copy that you have?
A. I don't think so. I think it's strange that my signature is not on this one. I'm happy to provide it if that's -- I could email back because of --
MS. PICKERILL: Can we go off record for a second?
(Discussion off the record.)
MS. PICKERILL: Okay. Thank you.

BY MS. CHIN:
Q. Are you prepared to offer your opinions today?
A. I am.
Q. Is there any information that you're still waiting on before providing your opinions today?
A. I don't think so, no.
Q. Do you recall that my office issued a subpoena to you for documents prior to this deposition?
A. I do.
Q. Hand you what I marked as Copley 2.
A. Thank you.
Q. This is titled Deponent's Response to Duces Tecum, and it's signed by one of the attorneys, Sheena Rosenberg. Have you seen this document before?
A. I have.
Q. Did you review it before it was submitted in this case?
A. Yeah. Yes. I'm just double-checking. Yes.
Q. To your knowledge are all the answers to these responses truthful and accurate?

A. To my knowledge, yes.
Q. I do want to ask you about response number two.
A. Okay.
Q. It's titled, a copy of any testimony, log of LaRae Copley, M.D., and you responded, no responsive documents; is that accurate?
A. It is.
Q. I know you said you've never testified in a deposition before. Have you ever testified at trial before?
A. I have not.
Q. Any other times that you've been under oath providing testimony?
A. Not under oath.
Q. Okay. All right. We can set that one aside.
I'll hand you what's been marked as Copley 3. Have you seen this document before?
A. I have.
Q. And this is your fee schedule?
A. It is.
Q. Are you still charging the same amounts on this fee schedule today?
A. To this client, yes.

Q. So looking at this, since we're in the discovery deposition, you charge $700 and if we go over two hours that would be another $350?
A. It is, yes.
Q. All right. I'll hand you what I've marked as, these will be three exhibits together, it's Copley 4, 5, and 6.
Let me know if you have seen these before.
A. I have.
Q. And these are the invoices that you submitted to the City of Columbus in this matter?
A. They are.
Q. Are there any invoices that you submitted that are not here?
A. I do not think so, no.
Q. So you haven't submitted an invoice yet for today?
A. I have not.
Q. So not including today, rough math, it looks like the City has paid you about $12,500?
A. That's not accurate actually, because you'll see that this is a retainer, and the retainer is taken off of Copley 5.
Q. Okay.

A. So we've got actually a total of a little over --
Q. Probably about $1,100 or $11,000?
A. Yeah. Little over ten; something in that range.
Q. Okay. We can put that one aside.
Thank you. Easier to get some of those documents out of the way first.
A. No problem.
Q. How long have you been doing expert work?
A. I've been doing expert work for about two years since I started a company called Copley Medical Consulting in 2022.
Q. What percentage of your income comes from expert work?
A. It has been variable. Would you like this year or last year?
Q. Let's start with last year.
A. Last year, a little over ten percent, I think.
Q. And how about this year?
A. This year thus far for all of my business, assuming that everything that is out comes in paid, it is less because I've had a change in salary.

Do math. One second.
So for the year of 2024 --
Q. Uh-huh. Yes.
A. -- approximately 15 percent, maybe. Approximately.
Q. Approximate is fine.
A. Yeah.
Q. When you've been retained as an expert, what type of work are you performing?
A. Sure. I've done different types of work in the past. I've been retained in the past by the State Medical Board to provide an expert opinion for a particular issue that they have or concern they've had, or I've been retained to evaluate charts for standard of care assessments before. I've been retained to evaluate clients of lawyers for potential harm, emotional harm, and that falls within psychiatry.
Q. When you've been retained to perform work with State Medical Board reviews and whatnot, have you provided any testimony or other sort of oral statements about what you had there?
A. Sure. I usually will come to speak with the committees on the board. It's not under oath. It's not officially testimony; just to review a

report that I've written after I've reviewed literature. When I've done work specific to a particular licensee, and I'm reviewing some of the work that they've done because there's -- the board has a concern, I have not come and done testimony at this point, just provided written reports.
Q. In the work that you're doing for maybe potential reviews of standards of care, what -- have those led to you being retained as a testifying expert?
A. They have the potential to -- for me to need to come to a hearing for the State Board of Medicine. That has not happened.
Q. So outside of the work with the State Board of Medicine have you been retained by attorneys for litigation purposes?
A. I have.
Q. And what has been the scope of those engagements?
A. So they have included going in and evaluating patients, or prior patients. They're not my patients, but patients, for emotional harm, they have -- and then preparing a report of opinions. I've also been hired to review just

chart work for malpractice, which does not include evaluating the person. It's usually, the question is, is there standard of care breaches in prior treatment.
Q. Okay. So you just haven't had an instance yet where your report work has turned into needing to testify either at a deposition or at trial?
A. Correct. Correct.
Q. In the work that you're doing for litigation purposes, what percentage of the time are you being hired by the defendant in the matter?
A. By the defendant in the matter. Let me think about that. Both -- I haven't had that many cases so I would have to sit down and think about it.
There are times that I am being hired by the plaintiff; times I am being hired by the defendant to review and -- on both sides and it does not result in a report written because the conclusion is not helpful to the lawyer who has asked me to review something. As far as a percentage of time, I get calls from both.
Q. Is it equal?

A. Yeah, I would say so. I would say so.
Q. And when you're writing -- when you get asked to write a report after a review, how often are you writing up for a plaintiff's counsel versus a defense counsel?
A. Sure. For litigation the purpose?
Q. Yes.
A. Let me think about that. I have written this one for defense. I have written a second one that's current and currently going on for plaintiffs and then I have work as part of my job as a fellowship where I'm actually hired by the courts. So I have a private practice for forensics and then I have work that I do as a forensic fellow.
Q. Explain that to me.
A. Sure. Absolutely.
So I was a practicing psychiatrist for a long time. I continue to be a practicing psychiatrist. I started a small business called Copley Medical Consulting. That's all private civil work. State Board of Medicine is through that work. Cases I've had for litigation have been through that work. Phone calls I get from lawyers about, would you be willing to review

this, is through that work.
In doing that work, I decided to go back and become a forensic psychiatry fellow with Ohio State University because I was getting calls for cases that I wanted to take and didn't feel like I should take because I didn't have as much legal experience, and I wanted to get that. So I'm currently a forensic fellow, and that involves criminal forensics.
And it's part of that work I am working -- and that's not private work through my own business, that's through Ohio State University.
As part of that work, I am involved in some private -- some civil work, I should say, not private work -- some civil work and but mostly criminal work. The criminal work is through the courts usually or it's been asked for by the hospital.
Q. Okay. With the civil work that you've done, civil litigation work, I know it sounds like you haven't been doing it for about -- you've been doing it for about two years?
A. Uh-huh. Yes. Yes. Sorry.
Q. Thank you.
About how many reports have you been

asked to generate?
A. For civil work?
Q. Correct.
A. I'm going to say five.
Q. Have you ever been retained before by the City of Columbus?
A. I have not been retained by the City of Columbus other than for this.
Q. How do you advertise your expert services?
A. I am part of an organization called Seek and they maintain a list of experts. But there's no formal -- like I don't have a website or anything like that. Most of the work that I get is word of mouth.
Q. Do you have to pay to have your profile appear on Seek?
A. I have paid in the past to have it appear. It's approximately $500 a year.
Q. Any other places that you advertise your expert work?
A. I have business cards that I give colleagues.
Q. When did the City of Columbus first contact you about doing work on this case?

A. It would be just prior to the date of this signature. We talked very briefly.
Q. The signature of the engagement agreement?
A. Yes.
Q. I don't know that I have a dated copy.
A. I'll happily provide you a dated copy. The date on the first invoice for retainer is in June; so I would say June 2024.
Q. How did the City of Columbus reach out to you?
A. I received a phone call.
Q. Do you know how they found you?
A. I don't. You would have to ask them.
Q. I will hand you what I've previously marked as Copley 7.
A. Thank you.
Q. And if you want to take a look at this and let me know if this is the most up to date CV of yours.
A. It appears to be, yes.
Q. Okay.
A. Yes.
Q. I'd like to walk through this with you just so I can understand your background a little

bit more.
A. Of course.
Q. So starting under the heading that is titled Leadership.
A. Uh-huh. Yes.
Q. It looks like you were medical director of Providers for Healthy Living for about two years; is that right?
A. I was. I was.
Q. And you finished that role in June of 2024?
A. I did.
Q. Why did you stop that role?
A. Because I made the decision to go into forensic psychiatry fellowship and that was a full-time position. It wasn't reasonable or appropriate to be a medical director part time for the people who needed me there all the time.
Q. And I think I know the answer to this question, but are you still operating Copley Medical Consulting, LLC?
A. I am.
Q. So Copley Medical Consulting would be February of 2022 through the present?
A. Yes.

Q. In your role as medical director for Providers of Healthy Living, what sorts of roles and responsibilities did you have?
A. Sure. So it was a full-time position that was approximately half seeing my own patients and then half administrative work. The administrative work actually included, in my mind, some clinical work because I was supervising the clinical treatment that my mid-levels, in other words, physician assistants, nurse practitioners, were providing to the patient population of the whole agency.
I was assuring there was adequate coverage. I was there for clinical consultation at any point, and then I would work with the leadership of this private practice to make sure that policies they were considering from a business perspective were a good idea clinically for people and for treatment. I would do teaching as part of that as well. I really saw myself as a liaison, and then I would see -- not quite sure how I want to say it -- I would see patients where -- I had my own caseload of patients, and I would see patients where someone on my team was struggling with the care of that patient; so I

would provide some second opinions. And then if a patient within the agency receiving care had concerns about their provider, there was some kind of disagreement, I would oftentimes manage those compliance, along with our patient care advocate.
Q. With -- so you said about half of your time was admin work, maybe plus a little bit of that patient care you just discussed --
A. Yes.
Q. -- but then half was your own patient care?
A. Right. Approximately. I was seeing patients on my own. I had my own caseload that then I maintained even after I left this medical directorship. I still see patients one evening a week.
Q. About how many patients do you treat within your typical caseload?
A. Currently right now?
Q. Let's start currently right now.
A. Currently right now I'm providing between -- I'm sorry, I didn't know -- I'm providing between three and four clinical hours on my own private caseload of providers of services a week of patients that I've seen long term for general

psychiatry.
Q. When you were medical director for Providers for Healthy Living about how many hours a week were you providing clinical practice patient care?
A. Where I am the physician taking care of the patient directly?
Q. Yes. Yes.
A. Approximately 17 to 20, depending on the week.
Q. What caused the drop from 17 to 20 to three to four?
A. Sure. Absolutely. When I started doing -- when I basically changed jobs and became a psychiatry forensic fellow, it just wasn't reasonable for me to do the work that I was signing up for as a forensic fellow and maintain even 15 hours a week of patient care. So it was separate to that. I have patient care as part of my forensic fellowship, but it just -- it wouldn't be responsible, in my mind, to do that. So I went through my caseload and arranged for patients to be transferred that I thought were -- maybe needed more than I could offer if I was just in that office a few hours a week.

Q. Let's turn the page here.
A. Sure.
Q. Talk some about your clinical experience.
A. Are we still on the CV?
Q. Yes, on the CV.
A. Sure.
Q. The top experience is the forensic psychiatry fellowship that we've been talking about?
A. Exactly.
Q. And so that would be July of 2024 through the present?
A. Right. It's a one-year program.
Q. After the one-year program, what do you anticipate doing?
A. That is a fantastic question that I haven't decided yet.
Q. Still early on in the program.
A. It's early on in the program. I will still -- I'm clear that I will maintain patient care. It would be very difficult for me to leave patient work.
Q. Why do you say that?
A. Because I am a physician. I love taking care of my patients. I don't know what I would do

if I weren't seeing patients. I could never be a full administrator.
Q. With this forensic fellowship, let's kind of go back and talk about all of the work that you're doing there. So you're doing some criminal work and civil work?
A. I am. The civil work is with one of my colleagues who does civil work. So a fellowship is an educational experience and so I am -- part of that is to be paired with multiple folks who are practicing forensics. Some of them do civil work; some of them do criminal work.
Q. Being paired with them, are you shadowing them?
A. So the word we would use in medicine is they are supervisors. However, it's a little bit tricky of a scenario because as someone who's practiced psychiatry before, and as licensed and board certified my need for supervision in the context of the State Medical Board is not there. It's my decision to work with colleagues who are forensic people so that I can learn more about forensics.
Q. When you're doing work for the State Medical Board, is it the State Medical Board

that's asking you to do the work?
A. Yes, through Copley Medical Consulting, yes.
Q. And that's not through the fellowship?
A. Correct. It precedes me deciding to do the fellowship.
Q. I'm trying to kind of piece out what you're doing with Copley and what you're also doing with the forensic fellowship piece. I know you explained a little bit about this, but can you provide a little bit more detail about what you're doing in the fellowship?
A. Absolutely. Sure.
So the purpose of the fellowship might be more helpful to start with. So the purpose of the fellowship is that after a year of experiences in forensics that I will take a board exam so I can be board certified in forensics. So there are certain requirements that have to happen during this year. That includes experiences like at the state hospital. It includes experiences in prison. So I go to the Ohio Women's Reformatory for part of the week. I go to TVBH which is now COBH; they just changed names. And I spend time at the Timothy B. Moritz Forensic Unit which is

maximum security to both provide care and to do reports.
So there's a difference between a treating psychiatrist and a forensic evaluator to mix these two roles. It's not a good idea. So I'm assigned in both of those roles for different persons.
Think about what else I do. I go to didactics. I teach as part of this. So I'm teaching both residents in medicine and then psychology interns in psychopharmacology. It's a very academic position. I hope that makes sense.
Q. Yeah. Thank you.
A. Yeah.
Q. The care piece of it -- so I'll break it down between the care and the treating piece you mentioned and the forensic evaluation piece.
A. Okay.
Q. The treating piece, that's similar to what you've been doing throughout your practice or since you've been a psychiatrist?
A. So it is -- it's treatment. However, it's an extremely different patient population. These are patients who are at a maximum security hospital, facilities. They are either -- they've

either been found to be incompetent to stand trial because of mental illness or they have -- they're being evaluated for those reasons acutely from jails or prisons, or they might have already been deemed NGRI or not guilty by reason of insanity and they're there for -- they've been remanded by the state to be there for treatment. So that's a very different population of psychiatric needs than the people that I see privately, which is what I would call field psychiatry, general run-of-the-mill psychiatry practice. Different people.

Q. The patients that you're treating now, I understand it's a different population.

A. Sure.

Q. But are you seeing these patients more than once?

A. I do sometimes. It depends on what their needs are. So I work with a particular attending who is treating them long term and I will work with him to see patients that he sees with them. So, yes, I see them more than once. I'm not officially the attending on the case. That's my -- I feel like it's splitting hairs.

Q. In talking about the forensic evaluation

piece of this role, are you producing reports with that --

A. Yes.

Q. -- or what are you doing?

A. Of the fellowship role?

Q. Yes.

A. Yes.

Q. What do those reports look like? I guess, what are you asked to do?

A. What's the consultation question?

Q. Yes.

A. Is this evaluees competent to stand trial? Does this evaluee have -- has this evaluee made adequate progress to have a different level of care within the hospital system? What is the violence risk if this person were to be recommended for a conditional release by the court? What is the violence or self-harm risk to this person? These are criminal questions that happen.

Q. When conducting these evaluations, do you see the patient once?

A. So I would see the evaluee as many times as needed but not in a treatment providing role. So I usually will see them once or twice

realistically.

Q. Thank you. That was helpful.

A. Sure.

Q. And it looks through this clinical experience that the second one down from the top, are you still a treating psychiatrist through Providers for Healthy Living?

A. Right. So this is in reference to the private caseload I keep for a few hours a week.

Q. The three to four hours?

A. Uh-huh. Yeah. Which is where I started, and then I took a job as medical director which became full time and then I went back to my few hours a week.

Q. And then one down from that, senior staff psychiatrist with Ohio State, it looks like you were there for about 11 years?

A. I was, and that was a full-time position.

Q. Full-time active clinical practice position?

A. So for part of that time I was the chief of psychiatry which had an administrative role. However, I was a full-time psychiatrist there. I carried a full caseload there.

Q. After 11 years, what prompted you to

leave that role?

A. I was in need of a change, of leadership, of ideas, of types of patients. I had begun working in a private place. So I had begun at Providers for Healthy Living working a few hours a week seeing patients in the community versus patients that were part of Ohio State's services. And it was just -- it was time for a change, time to do something different.

Q. So you were with Providers for Healthy Living and Ohio State for two years at the same time?

A. Concurrent, yes. So I was full time at CCS at Ohio State and seeing patients for four hours a week. Yeah.

Q. Is that general in, I guess the psychiatry field, that psychiatrists may treat patients through two different entities?

A. Absolutely. Absolutely.

Q. And then teaching experience, which is on the third page, are you currently teaching any classes?

A. I am. I'm teaching a psychopharmacology class for psychology interns at Ohio State. It's part of their seminar series. It's not something

that -- it's part of their seminar series. I don't want you to think, oh, I taught this semester-long course. It's five hours of teaching, but it's on the topic of psychopharmacology over the course of a month and a half.

Q. What is psychopharmacology?

A. The use of medications within psychiatry and psychiatric illnesses.

Q. How many years have you been a psychiatrist?

A. I graduated from residency 2010, was board certified since 2011 but have been practicing with my independent license in medicine since 2009. You have a training license as a resident and at some point during that time you get your full license is how that works.

Q. So about 15 years?

A. About 15 years, yes.

Q. In your professional capacity as a psychiatrist, have you ever been sued by a patient?

A. No.

Q. We can put that aside.

I want to focus for a moment on how you

interact with patients in your clinical practice. So putting the kind of report generating, litigation piece aside --

A. Sure.

Q. -- when you're asked by attorneys or other entities do that type of work.

A. Okay.

Q. In your clinical practice, do you ever diagnose patients without meeting them?

A. No.

Q. So you would never do it solely off of a records review?

A. I'm -- no. I would have an opinion about how if the records supported the diagnosis that was given by another clinician; but, no.

Q. In your clinical practice do you ever diagnose patients only meeting them once?

A. Do I ever diagnose a -- I will always provide a provisional diagnosis upon meeting a patient if I -- if the purpose was to assess them for treatment. It's never with the intention of not meeting them again, but there will always be patients who come and see you once and don't return. So never intentionally, I should say.

Q. Would you in your clinical practice ever

prescribe medication after only one meeting with a patient?

A. Yes.

Q. What would happen if then the patient never returned to see you again?

A. So if they never returned to see me again?

Q. Yes.

A. So I'm very conscious of prescribing medication. So I'm not willing to prescribe a long-term prescription. We might prescribe a trial amount of medication with the plan that you're coming back to see me so we can see how it went.

Q. What would be the length of maybe a trial period?

A. 14 to 30 days depending on the type of medication or the needs of the patient.

Q. And part of that is because then you'd want to make sure that they come back and get evaluated by you again?

A. Absolutely. I want to make sure they're doing okay.

Q. And that the medication is either working, or if not, adjust it?

A. Absolutely. And make sure there are no side effects to the medication or no concerns about that course of treatment, no questions.

Q. In your clinical practice how often are you meeting with a patient?

A. So it will always depend on the needs. It could be anywhere from once every week or two to once every three months depending on the patient's stability and clinical needs. I tend to not go over three months. It's not an ODMH recommendation.

Q. Are you meeting with patients in person? Do you do anything over Zoom?

A. So currently I'm doing a fair amount of telehealth. Prior when I was working as medical director, I did both. I had clinic days in house. I had zoom-based appointments and I would determine if patients needed to -- if they need to be seen in person or not clinically.

Q. When you see a patient how long does that appointment last?

A. It could be anywhere from thirty minutes to an hour depending on what the patient needs.

Q. In your clinical practice, besides prescribing a possible medication, would you come

up with a treatment plan after only meeting a patient once?
A. Absolutely.
Q. And what happens if the patient then never comes to see you?
A. So their follow-up plan is part of that treatment plan. So if they don't, I would -- so, for instance, let's say, the patient would always leave my office with an appointment scheduled. So then if that appointment were to be canceled or the patient didn't show for that appointment, either I or our office staff will reach out to them to try to reengage them or to see if there's anything that we can help provide. It's a pretty standard practice. Recognizing that the patient has the choice to engage in that or not. Sure.
Q. Based on your clinical experience, is it common for a patient, I guess, maybe if this is the right term or not, and correct me if it's not, but psychiatric status to kind of change over time?
A. Absolutely.
Q. Can it change from day to day?
A. Can a patient's status change from day to day? It would depend on what I'm treating; but,

yes, certainly.
Q. All right. Let's talk about this specific case now. You understand that we're here for a lawsuit where an individual who was an ATF agent is suing the City of Columbus and some of its police officers?
A. I do.
Q. What did the City of Columbus ask you to do in this case?
A. So the City of Columbus asked me to look at the treatment that they had from the officer -- I should say the ATF agent, Mr. Burk, and to evaluate him for any concerns around PTSD or emotional harm based on data that they had received from his treating providers.
Q. And I think we both know who we're talking about who the -- when you say Mr. Burk, it's James Burk --
A. Yes. Yes.
Q. -- the plaintiff in this case.
A. Yes.
Q. So the City of Columbus asked you to review the records. When did they ask you to complete an evaluation of Mr. Burk in person?
A. When did they ask me -- when did I know I

would be doing that?
Q. Yes. Was that part of the initial engagement?
A. Yes.
Q. In your professional work doing kind of generating reports or the, you know, expert work that we've talked about, have you provided opinions when you've been generating reports solely off of records reviews?
A. For the purposes of malpractice; not for the purposes of saying what a patient is or is not suffering with.
Q. So when you're asked to look at the patient's kind of emotional harm or suffering, emotionally, mentally, you are meeting the patient in person and in having that evaluation?
A. Absolutely. I wouldn't be able to render an opinion without meeting them.
Q. So in this case you did ultimately end up evaluating Mr. Burk?
A. Yes.
Q. When you evaluated Mr. Burk, you at that time knew that the City of Columbus had hired you?
A. Yes.
Q. I'm going to hand you what's been marked

as Copley 8.
A. Thank you.
Q. This is your report that was provided to us in this case. Can you take a look through this and let me know if it's accurate?
A. It appears, yes. It's dated appropriately and has my signature on it.
Q. Any changes to your report since September 13, 2024?
A. No.
Q. Since September 13, 2024, has the City provided you any additional documents or records?
A. No.
Q. Let's turn to page 2. You'll see you have sources of information there, the second heading. Do you see that?
A. Uh-huh.
Q. Who provided you this information?
A. This information was provided either through the City of -- so it was provided through the City of Columbus either from Ms. Pickerill or Ms. Rosenberg.
Q. When did the City provide this information to you?
A. I was not provided all of it at once,

just based on as things came in. I received the first set of records when I was hired in June.

Q. When you evaluated Mr. Burk in person, did you have all of these documents before you evaluated him?

A. So I had all of the documents with the exception of number 14. And there was a question about whether or not that -- I didn't -- I had not seen that document beforehand and so I had asked about further information and got documents.

Q. With documents, the first one is the four-hour evaluation of Mr. Burk. So I won't include that in the documents. But with documents 2 through 13 you had all of those before you met with Mr. Burk in person?

A. I believe that is true, yes. So I -- I actually met with doctor -- I met with Mr. Burk on 8/30. The video of him was taken on 8/29. I don't know that I had that video before I -- number seven, I don't know that I had number seven before I met with him. I believe I received that after the fact. Okay.

Q. Let's just walk through these one by one then. So number two is the complaint. You had that before you met with Mr. Burk?

A. Yes. Yes.

Q. Did you review that before you met with Mr. Burk?

A. Yes. Yes.

Q. Number three, did you review that before you met with Mr. Burk?

A. Yes.

Q. Number four, did you review that before you met with Mr. Burk?

A. Yes.

Q. What about number five?

A. Yes.

Q. Did you review that before with you met with Mr. Burk?

A. Yes.

Q. Number six, did you review that before you met with Mr. Burk?

A. Yes. Yes.

Q. Number eight, did you review that before you met with Mr. Burk?

A. Yes.

Q. Number nine, did you review that before you met with Mr. Burk?

A. Yes.

Q. Number ten, did you review that before

you met with Mr. Burk?

A. I actually am not sure because that says current PCP, and I believe that those records came in afterwards.

Q. Is it possible you had those beforehand?

A. I don't recall that I had those beforehand. I believe it was after.

Q. Number 11, did you review those letters before you met with Mr. Burk?

A. Yes.

Q. Number 12, did you review the letter from Sean Riley before you met with Mr. Burk?

A. Yes.

Q. And number 13, did you review the letters from Dr. Bienvenu for disability retirement before you met with Mr. Burk?

A. Yes.

Q. So when you met with Mr. Burk you already had a fair amount of background about him?

A. I did.

Q. And you already had information about the underlying allegations of the case?

A. Yes.

Q. And you already had an understanding of the incident that occurred on July 7th of 2020

that's the subject of this case?

A. I had an understanding, but not necessarily his understanding until I met with him.

Q. If I use the term incident, can we agree that that's the July 7, 2020, incident that occurred between CPD and Mr. Burk?

A. Yes.

Q. In your clinical practice, how often do you receive records about a patient prior to meeting with that patient?

A. Reasonably commonly.

Q. What types of records are you receiving about a patient beforehand?

A. So I will receive at the very least for clinical work the patient's account of why they're coming in to see me, the reason they're seeking psychiatric consultation or psychiatric treatment. I oftentimes have records from other psychiatric providers and other primary care folks depending on if the patient has provided those beforehand, and then if they have not I will ask them to provide them so that I can understand their -- I can get collaborating information about how they've been doing.

Q. So you for some patients may have prior medical records before you meet with them?
A. Absolutely.
Q. And you'll review those before you meet with them the first time?
A. Yes.
Q. And you may -- and you also get the patient's account for why they are seeking psychiatric treatment?
A. Yes.
Q. The patient's account, how is that generated?
A. I do a clinical interview of the patient. Is that how you mean?
Q. I guess you said you get the patient's account for why they're seeking treatment before you even meet with them.
A. Oh, yes. I'm sorry. I didn't understand your question.
So patients when they're seeking care they usually are given packets of questions to fill out about all sorts of things, including why they are looking for psychiatric care. And so we ask them to provide some general information about why they're seeking care. What symptoms they have

been struggling with and what they are specifically concerned about seeking care for.
Q. So it's kind of a like, I guess, new patient packet that you may fill out when you go to the doctor's office?
A. Absolutely. That's a great way to say it. Most people have done that if they ever sought medical care at all. Something like that.
Q. Have you within your clinical practice received other types of documents besides that initial patient, new patient packet or prior medical records about a patient before you've met with that patient?
A. I usually would receive predominantly clinical information. There have been times that I am being referred a patient by another provider, such as a psychotherapist or some -- I've received a consultation, someone has asked me to see their patient for a reason, in which case I might receive their records or I might receive -- we might have a phone call, for instance, about particular concerns. But it's clinical information typically.
Q. In your clinical practice have you ever received video footage before meeting with a

patient about that patient?
A. Have I ever received -- not in clinical practice.
Q. In your clinical practice have you received employment records about that patient before you met with the patient?
A. I have received letters that perhaps a patient has given me related to employment difficulties; but I've never received a full HR pack.
Q. Okay. So you've never received like a disciplinary file about a patient before meeting with that patient?
A. I have not. Not for clinical work.
Q. Have you ever received in your clinical work, any testimony that the patient's provided before you've met with them?
A. Not that the patient's provided, no.
Q. You say not that the patient has provided, so, I guess, has there been an instance in your active clinical work where you've received that testimony from another source?
A. Not deposition testimony or transcripts. I might be aware, due to the clinical thing that's bringing the patient to me, that they have legal

proceedings around something and they're giving me that information. They're telling me that they've put that in their packet. But I've never received testimony as part of that.
Q. Okay. Let's move to page 3 of your report.
A. Sure.
Q. From my understanding, this looks like pages 3 through maybe the first third of the page of page 6, this is background information and prior functioning of Mr. Burk.
A. With the exception of the confidentiality disclosures, yes.
Q. And you generated this summary?
A. I generated this summary, yes.
Q. And under the heading, Background Information and Prior Functioning on page 3, you mention: "The following is the summary of salient parts of Mr. Burk's historical information taken from both available records and the evaluation on August 30, 2024."
When you generated this summary, how do you decide what is a, I guess, salient part of Mr. Burk's historical information?
A. Sure. So I try to always take an

educational history just as part of my practice, an educational history, a vocational history, because these oftentimes speak to functioning. I try to take a relationship history. They speak to functioning. And so and I will take a trauma history. I want to understand where this person grew up, what their culture background is, what types of experiences they had as a child, an adolescent and as a young adult. I try to assimilate that into something that is readable and understandable for me and for the Court.

Q. And so moving through his other history, on page 6, you have past psychiatric history. Is that still a summary that you generated?

A. It is.

Q. Is this, I guess, heading included in background information, prior functioning or is it a separate kind of piece for you?

A. I think of it as a separate piece.

Q. Okay. And what did you base the past psychiatric history on?

A. So I based the past psychiatric history on the records I received from his treating psychiatrist, Dr. Bienvenu -- I really hope I'm saying that right -- Dr. Bienvenu as well as the

work that -- or his discussion of it. I asked him questions about it, about his past psychiatric history during the exam. And then I had information from Bayside Marin. That is in there as well, as well as what he told me about that experience too.

Q. This summary from past psychiatric history is coming from your review of the records and also what Mr. Burk told you?

A. Yes.

Q. Any other place that that's coming from?

A. No.

Q. Okay. The substance abuse history, you know same questions, this is still a summary generated by you?

A. Yes.

Q. And is this summary also, again, coming from what Mr. Burk told you in your records review?

A. Yes.

Q. Any other places, any other sources that this summary comes from?

A. No.

Q. His past medical history, this is a summary, again, generated by you?

A. Correct.

Q. In this summary, you base this off of what Mr. Burk told you and his medical records?

A. Correct.

Q. Any other records or sources that you considered with his past medical history?

A. No. Just his medical records provided to me and what he told me.

Q. For his medications on page 7, this is another summary generated by you?

A. It is.

Q. And that comes from what Mr. Burk told you and the medical records that you reviewed?

A. It does.

Q. Any other sources?

A. My knowledge of psychopharmacology is where the footnotes come from.

Q. The prescriptions that you referenced on the bottom of page 7 -- oh, boy. I'm going to try to say these, but --

A. It's okay.

Q. Losartan.

A. Losartan.

Q. Is that -- that's a blood pressure medication?

A. True.

Q. Is there any use for losartan in a --

A. Psychiatric way?

Q. -- psychiatric way?

A. No.

Q. How about number six, there?

A. Amlodipine is also a blood pressure medicine. It was being prescribed by his primary care folks. So, no, it's not a psychiatric medicine.

Q. How about the footnote number seven?

A. Atorvastatin is also for his cholesterol. It's not for a psychiatric reason.

Q. And ibuprofen is over-the-counter pain medication?

A. Yes. Yes.

Q. So pages 9 through 13 you provide a long summary of the collateral sources that you reviewed; is that correct?

A. This is a review of records from his treating psychiatrist, Dr. Bienvenu, and I broke this down by year because he has been seeing him for several years.

Q. When you were generating these summaries of his treatment with Dr. Bienvenu, I guess, what

is your process for generating these summaries?

A. Sure. So I will have those records pulled up, preferably on a computer, not in a big box. These were on computer. And I'm reading them looking for symptoms that he's reporting over time that -- excuse me, that Mr. Burk is reporting over time. I'm looking for what treatments he received and I'm looking for the assessments that Dr. Bienvenu or the treating physician or provider made based on what he was reporting. So I'm trying to look at the whole -- I'm trying to look at the big picture of what's happening for the patient at the time.

Q. You include, you know, a lot of specific dates in your summaries here. And from your review, are these dates that Mr. Burk had an appointment with Dr. Bienvenu?

A. Yes.

Q. And do you include all the appointments in this summary?

A. So I include the overwhelming majority of them because usually something is happening in those appointments. So he was seen multiple times. And I've listed the dates here so that you could go back and read that note if you wanted

more information.

Q. Let's turn to page 15. I want to look at the bottom of 15. There's a piece that's titled, Insight and Judgment.

A. Uh-huh.

Q. See that?

A. Uh-huh.

Q. And I guess I should mention that this is under the heading of Mr. Burk's current mental status?

A. Yes, ma'am.

Q. This current mental status or -- is this still a summary?

A. So mental status is what I saw. That would be the equivalent of when your primary care doctor does a physical exam. They document what they see that day.

Q. So these -- Mr. Burk's current mental status what you've written here are your perceptions of Mr. Burk after meeting with him?

A. Correct. From that exam, yes.

Q. From the exam.

A. Yes. Yes.

Q. In any part of this current mental status are you considering any medical records or

underlying documents that you reviewed?

A. I'm not sure I understand the question. I'm sorry. Could you say it again?

Q. Yeah. When you're describing your perception of Mr. Burk's current mental status as you did in this section, when you are describing that, are you considering his medical records with Dr. Bienvenu?

A. I am not because I'm doing my own exam of the person; but I have information from those records which he's reviewing with me as part of this whole experience. But I'm not walking in with a preconceived notion about what I'm going to see, which is what I think you might be asking me.

Q. So I guess what I'm wondering, is because you had reviewed all of his medical records and the other documents, not all of them, but a majority of the documents that the City of Columbus had provided you beforehand, that's -- you have that background knowledge at the time that you are also writing these current perceptions of Mr. Burk?

A. I do; because I know what he was complaining of in the exam when I spoke to him, and he made reference to those. So we talked

extensively about his experience with the ATF, with the incident on the day when in treatment.

Q. We have been going for over an hour. Do you need a break? Are you doing okay?

A. I'm fine. Thank you.

Q. Okay. So turning back to page 15. I want to look at Insight and Judgment at the bottom there. You write, "His insight was fair to good regarding his described symptoms and their impact."

A. Uh-huh.

Q. What does fair to good mean?

A. So it means fair to good. It means not fabulous, not completely without insight.

Q. When you are describing something as fair to good as a psychiatrist, is this on a scale?

A. So I think of it on a scale but I don't usually say, oh, it was 5.3 out of because I did this measurement.

So, for instance, Mr. Burk had insight into the fact that he had some symptoms and he was having some struggle. So I'm always interested in that. He had insight into how some of his life stressors could be impacting that. He had insight into how he had received help in treatment.

He struggled a little more when I asked him to consider is there an alternate way to understand his symptoms or when I asked him about alternate ideas.

Maybe an example would be more helpful.

Q. Yes. Sure.

A. I apologize. So, for instance, in his military history, if you go back, he said that -- he said to me that he had seen difficult things in his military history. He was in danger during his military history at times, but -- and he had some emotional response when talking to me about that -- but then he very quickly said, I signed up for that. It doesn't bother me. And I pushed a little on that and he just -- he had some emotional appearance to me at the same time. It was like that's what I signed up for. It's in the past, bury that. And I don't know that that's fabulous insight, ten-out-of-ten insight.

Q. With his prior military history, you mention he maybe felt emotional when he spoke to you about it.

A. Uh-huh.

Q. Did he provide you any specific examples of a traumatic experience that he went through in

his military history?

A. Yeah. So I asked him if his life was ever in danger. And he said to me, well, we didn't have warfare every day. But in that implication was, you know, we were prepared to be soldiers. And his quote in here is slashing and -- I apologize. I'm going to find the quote because it struck me is why I put it in the sentence and I don't want to misquote him.

So he talked about being part of Meusoc, M-E-U-S-O-C, and always had to be mission ready. When I made this reference before they are always prepared to go when they say they are mission ready. And he said, you know, we had isolated incidents when my life was in danger, but it wasn't in the trench, not cutting and slashing although you're trained to do it. He said, you know, I don't know that a lot of that bothered me. I don't think it affected me adversely. But I saw this emotion when he talked about that and then I saw this again in his -- when he talked about his experiences as a police officer and seeing children. He was -- you know, I watched this man hold back tears when we talked about it.

Q. When you quoted Mr. Burk throughout, you

know, this is the summary that you have here, for example, the passage you just read, are these quotes that you're writing down as you're talking to him?

A. So I'm making a note of them but then I have an audio because it was a recorded examination.

Q. So you went back and listened to the recording as you were generating this report?

A. Yes. Yes.

Q. I still kind of want to get a better understanding of your scale when you're talking fair to good.

A. Sure.

Q. What I guess would be the adjective that you're using at the lowest level?

A. Fair. Or the lowest level of the scale?

Q. Yeah.

A. None.

Q. What is above none?

A. Some.

Q. And then what comes after some?

A. Fair.

Q. And then good?

A. Uh-huh.

Q. And --

A. Full. I would usually say full.

Q. Instead of good or above good?

A. I would usually say good to full.

Q. So we go none, some, fair, good to full, what --

A. And I'm done. And then I'm done.

Q. And then you're done.

A. Yeah. I don't think anyone has perfect insight. We all have our biases.

Q. Is this scale something that you use as a psychiatrist or is it something that is used in the practice of psychiatry?

A. It is used in the practice of psychiatry. Psychiatrists have words they use to communicate with other psychiatrists. Yes. You're not going to find this in a piece of literature, research study. It would be the same as if I said that he was well groomed as opposed to not well groomed.

Q. Because some of that is coming off of your perception --

A. Absolutely.

Q. -- of what it is?

A. Absolutely. It's part of the clinical exam.

Q. All right. At the bottom of 15, and really moving towards 16, since there's only one line there.
A. Uh-huh.
Q. You had administration of the structured interview of reported symptoms, SRS-2.
A. Correct.
Q. What is the SRS-2?
A. The SRS-2 is a 172-item psychological test that looks at different symptoms that people report, and it combines those with symptoms that are less likely, more seldomly reported. It has the purpose of trying to understand the style of reporting symptoms that a patient has; so how engaged they are. And it has some repeated questions on it that allow the examiner to look for any signs feigning symptoms.
Q. Do you administer the SRS-2 in your active clinical practice?
A. In my active forensic practice, yes. This is a forensic type exam. In my clinical practice, I'm not forensically evaluating patients. I'm providing treatment.
Q. With the SRS-2, you said it's 172 questions, right?

A. Uh-huh. Uh-huh.
Q. Is this on a sheet of paper when you're administering the test?
A. Sure. So the test is, as are most neuropsych tests, you have a packet of questions, and that's for that patient. And that is -- you pay per test to administer it.
So I don't just have a set of questions that I use all the time for, like, here's my printout of the SRS-2. I have a packet for that patient.
Q. Okay. In the packet of the patient, you ask question one, patient answers, right?
A. Uh-huh.
Q. And how do you document the answer to that question?
A. So the packet that I have has on it a -- the SRS is based on, yes, definitely, no, maybe, is what it's based on for many of the questions. And then I would -- I would rate that based on what the patient tells me. I don't say to the patient nor would the standard administration say that I should say to them, yes, please answer yes, no or maybe. I say we're going to do some short answer type questions. I'm looking for general

answers. And then I will -- if the patient were to say something extra, I would note that.
Q. For Mr. Burk, there's a packet for his SRS-2?
A. There is.
Q. And you still have a copy of that?
A. I do.
Q. I don't believe that was provided to us as part of your expert file.
A. It's proprietary and it breaks the test security, and so I didn't. I provided an audio recording of me giving the SRS-2 so you can hear it. And then I have the results in here.
This is -- you have to have certain qualifications to purchase this test to show that you're qualified to give it. If it ends up on the internet, then people know how to break a feigning test.
Q. You said for his results that he was in the genuine responding category?
A. True.
Q. What are the different categories that an evaluee can land in?
A. So genuine responding: so consistent, which basically means they're consistently

reporting symptoms and experiences. You can land in what's called non -- it's like a nonengaged. Like if a person said no to every single question, no, no, no, no. It's like they are not engaged with the test. And then you can fall into probabilities for feigning, if you will. So likely feigning or likely over reporting or overexaggerating to a more definite. It has to do with how high the score is. I hope I'm explaining that so that -- do you know a what I mean? Does that answer your question?
Q. Yes. Thank you.
You mentioned that this is a neuropsych test?
A. It's a psychological instrument, yes.
Q. In your work in the forensic psychiatry field, have you reviewed SRS-2 packets for evaluees that other psychiatrists have filled out?
A. I have not reviewed one that another psychiatrist has filled out, no.
Q. When you were evaluating Mr. Burk, did you feel rushed on time?
A. Not at all.
Q. When you were evaluating Mr. Burk, did you have any reason to believe he was not being

truthful in his answers?
A. Not when I was sitting with him, no.
MS. CHIN: Let's go off the record for a second.
(Brief break.)
BY MS. CHIN:
Q. All right. We're back on the record.
Dr. Copley, I want to turn now to your opinion portion of the report, which starts on page 18.
A. Thank you.
Q. So based on your education, training, and experience you agree that Mr. Burk has PTSD?
A. I do.
Q. I want to look, there's just a few pieces I want to understand a little bit better here. On letter F, which is on page 20.
A. Okay. Yes.
Q. And you use this word in a few places. You use the word "disturbance." What is disturbance?
A. So this is directly from the DSM criteria. It's a word they use. So what is really meant is the duration of symptoms that are causing functional impairment.

Q. On letter H, you opine that there's no evidence that Mr. Burk's symptoms are attributable to a medical condition or substance. Do you still agree with that opinion?
A. I do.
Q. The paragraph down from that, the second sentence, you write, "While he does not identify a clear prior event of trauma in his history, he's described multiple potentially traumatic experiences in his history during his time deployed as a soldier and as a police officer."
We've talked about this a little bit before, but in your evaluation of Mr. Burk, did he provide you any specific examples of traumatic experiences that he had been through?
A. So he provided more general experiences of times when his life was in danger and would talk about. So I'll go back to the example he gave in general about seeing children that were neglected or were -- had been abused. He said, you know, you weren't -- I'm going to paraphrase -- he basically said you're not trained for that. It just gets you in your gut. And he compared that to the distress that you might have if your life was directly in danger.

He talked about if you're going into a dark building, you don't know who's in there. You don't know if you're in danger. It's like the being on edge and the hypervigilance of that is stressful but that he felt more prepared for that than the emotional impact of seeing, I believe he said abused children and sometimes old people left to die. He gave the example of, you know, those kids don't have a dog in the fight and how upsetting that was to him; but he didn't talk about a specific on July, whatever, blah, blah, blah, this thing happened.
Q. And so you write here that he described multiple potentially traumatic experiences. Why did you use the word potentially?
A. Because he didn't say to me on December 1, 2003, I witnessed the blah, blah, blah, blah, blah. He didn't -- and so I wanted to -- I wanted to point out that we talked very generally about his experiences as a law enforcement officer and as a soldier.
Q. You would agree that experiences can affect people in different manners?
A. Okay.
Q. Correct?

A. Absolutely.
Q. So something that one person feels is a traumatic experience may not be a traumatic experience for another person?
A. Yes, and -- yes, yes.
Q. So I guess stated differently, what you or I may think as traumatic may not be something that Mr. Burk feels traumatic?
MS. PICKERILL: Objection. But go ahead.
THE WITNESS: That is possible and yes. Yes, that's possible. I'm trying to understand your question.
BY MS. CHIN:
Q. It can depend -- a person's response to a traumatic experience depends on that individual person and how they respond to it.
A. Yes. Yes. Thank you. You said it better than I was going to answer it. Thank you.
Q. And you agree -- so we've established that you agree that Mr. Burk suffers from PTSD?
A. Yes.
Q. And you agree that that PTSD comes from the July 7, 2020, incident?
A. I agree that that is part of it, yes.
Q. When you say in part, what do you mean?

A. So Mr. Burk has risk factors in his prior history to develop a PTSD response to a traumatic event. And so it would be impossible for me to say that Mr. Burk had absolutely nothing happened to him and then on a particular day as an event and now every single thing from that point forward is due to that particular event; because he had other things prior.

Q. In these experiences that he had prior may -- you're saying may be kind of piece of the puzzle of his PTSD?

A. Yes.

Q. And somebody who's experienced traumatic events, are they more susceptible to, you know, a PTSD response in the future to a traumatic event?

A. They are. In particular, if I may, he discussed with me having claustrophobia. I'm going to use that word in a lay way. That is not a DSM diagnosis. He described lots of difficulty with small spaces. He wasn't able to link that to a particular traumatic event, but it's been consistent throughout his history. I think that having that potentially made his experience of the incident scarier to him, more distressing in that moment; but I cannot attest to what caused that

claustrophobia prior. That would be an example.

Q. So putting it in a different way, based off of your evaluation of Mr. Burk, he had some underlying conditions prior to July of 2020?

A. Risk.

Q. Risks.

A. Yes.

Q. That could contribute to his PTSD response from July of 2020?

A. Yes.

Q. Do you agree that Mr. Burk experiences symptoms from his PTSD?

A. I do.

Q. Would you agree that a person suffering from PTSD may find it difficult to engage in life activities?

A. A person, any person?

Q. Any person.

A. Yes. They would have functional impairment by definition of the diagnosis.

Q. Would you agree that a person with PTSD may feel fear in certain situations?

A. Yes. Yes.

Q. And they may feel fear particularly in situations that cause them to relate back to a

traumatic experience?

A. Yes.

Q. Would you agree that a person with PTSD may feel anger?

A. Yes.

Q. Would you agree that a person with PTSD may become irritable?

A. Yes.

Q. Would you agree that a person with PTSD may find that it's difficult to sleep?

A. Yes.

Q. Would you agree that a person with PTSD may feel detached from other people?

A. Yes.

Q. Would you agree that a person with PTSD may feel estranged from other people?

A. Yes.

Q. So given some of these symptoms, would you agree that PTSD can affect how a person reacts in certain situations?

A. Yes.

Q. It can affect how a person acts day to day?

A. Yes.

Q. It can affect even how they may handle

day-to-day tasks?

A. It may, yes.

Q. It can affect -- PTSD can affect how a person communicates with other people?

A. It may.

Q. And PTSD can affect their relationship with other people?

A. It may.

Q. PTSD may even affect a marriage?

A. It may.

Q. Can a person fully recover from PTSD?

A. Yes.

Q. How do they do that?

A. Great question. So from the -- in a purely record type situation they just don't meet these criteria anymore. However, in treatment, many times people will seek psychotherapy as well as medication management to assist them with the physiological symptoms that happen when they are triggered, for instance, by memories that they can't control. Usually exposure to this over and over again will help abate that. People have significant improvement once they're able to do that.

So I have seen many folks who no longer

will meet these criteria for PTSD after a traumatic event because they've undergone therapy and sometimes medication management for PTSD specifically.

Q. Do you only diagnose people with PTSD if they meet this, what is it --

A. These criteria.

Q. -- these criteria?

A. So I would -- so, for instance, if I met somebody who had a traumatic experience who is no longer meeting criteria, I would note that in my medical record. The question is, are the symptoms still functionally impairing. So it would be like PTSD by history. You can remit from PTSD. You can no longer have functional impairment after you've experienced a period of PTSD symptoms.

Q. And your criteria that you're using are the DSM-5-TR?

A. Correct.

Q. When you say someone is in -- I guess you're using remission as a term for PTSD?

A. So that is not a DSM-5-TR word. But they no longer meet the criteria. Remission is a very specific word in the DSM used applied to other diagnoses. They do not apply it to PTSD. So I

would write, "this patient reports a history of PTSD." That's how I would write it in my chart. Because I know that I want a full history of any patient I treat but that might not be the subject of clinical concern currently.

Just like you might have a history of hypertension and then you lost a hundred pounds and now you don't have it anymore.

Q. With somebody, I guess, when you're using the term history of PTSD, does that mean that that person will never experience PTSD symptoms again?

A. It means that when I write history of PTSD of someone I'm seeing right now, means they don't have them now.

I'm lousy at predicting the future. My crystal ball is not good.

But they have risk.

Q. It could come back.

A. Sure. They have risk. The hallmark of PTSD is getting triggered and it being -- it kind of all coming back up again and eliciting some distress. That is a hallmark core symptom of PTSD. I don't try to trigger my patients to see if that happens.

Q. Can a person be cured of PTSD?

A. Define cure.

Q. Have you ever in your active clinical practice had a patient that -- strike that.

Can a person be cured of PTSD to the effects that you know that they'll never experience PTSD again?

A. That they'll never experience it again? Never is a big word.

What I would like to say to you is I have patients that I have seen who had very severe symptoms, received good treatment and have not had documented PTSD symptoms for years afterwards.

Q. So there's a way with treatment that can help you manage the PTSD?

A. Most definitely.

Q. But that doesn't necessarily mean that you're never going to experience PTSD again?

A. Correct. Correct.

Q. Give me one moment, please.

You've, as we discussed, been retained in this case as a testifying expert?

A. Yes.

Q. And you probably understand that we may be going to trial in this case in a little bit over a month?

A. I didn't know it was over a month; but, yes, I understand trial could happen.

Q. Have we discussed all of the opinions you intend to offer at trial today?

A. All of the opinions I intend to offer in this. I'm not sure that we have discussed all of them.

So we did not discuss the -- it's on page 22. We did not discuss either Mr. Burk's temperament and how this may have -- may lead to distress. And we did not discuss that some of the symptoms that he was reporting to Dr. Bienvenu were, in my opinion, not exclusively secondary to trauma.

Q. Let me put it this way. Are there any opinions not reflected in your report that you intend to offer at trial in this matter?

A. No. No.

Q. Are there any opinions reflected in your -- are there any bases of your opinions reflected in your report that are not reflected in your report? That was a bad question.

A. I don't know what you mean. I'm so sorry.

Q. Your report fully reflects the bases of

your opinions?
A. Every opinion offered, there's a basis for based on what I was given.
Q. Have you been asked to do any other work in this case?
A. No. I'm not sure I know what you mean.
Q. Have you been asked to supplement your report?
A. Not to supplement my report, no.
Q. Have you been asked to do any additional evaluation of Mr. Burk?
A. No.
Q. Is there any other work to this date that you intend to do on this case?
A. Should records become available from his prior experience at Bayside Marin, I would be very interested in evaluating those.
MS. CHIN: I don't have any further questions.
MS. PICKERILL: I don't have any additional questions.
You have the right to read the transcript before you sign it just to make sure that there are no typographical errors. You can't change any of your answers or anything like that. You can

also waive that right. It's up to you. But we recommend generally that people read the transcript.
THE WITNESS: I'm happy to read it.
MS. PICKERILL: We'll read it if you don't mind.
--|--
Thereupon, at 10:36 a.m., the deposition of LARAE COPLEY, M.D. concluded.
--|--

AFFIDAVIT

State of Ohio)
) SS:
County of _____)

I, LARAE COPLEY, MD, do hereby certify that I have read the foregoing transcript of my testimony given on Friday, September 27, 2024; that together with the correction page attached hereto noting changes in form or substance, if any, it is true and correct.

_____
LARAE COPLEY, MD

I do hereby certify that the foregoing transcript of the deposition of LARAE COPLEY, MD was submitted to the witness for reading and signing; that after she had stated to the undersigned Notary Public that she had read and examined her testimony, she signed the same in my presence on the _____ day of _____, 2024.

_____
Notary Public

My commission expires _____, _____.
--|--

CERTIFICATE

State of Ohio)
) SS:
County of Franklin)

I, Carla D. Manahan, RPR, the undersigned, a duly qualified and commissioned Notary Public within and for the State of Ohio, do certify that LARAE COPLEY, MD was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth; that the foregoing is the deposition given at said time and place by LARAE COPLEY, MD; that I am neither a relative of nor employee of any of the parties of their counsel and have no interest whatever in the result of the action.
IN WITNESS WHEREOF, I hereunto set my hand and official seal of office on this 1st day of October, 2024.

_____
Carla D. Manahan, RPR
Notary Public, State of Ohio
My Commission Expires:
January 24, 2025

ERRATA SHEET

Deposition of LaRae Copley, MD taken September 27, 2024

Please list any changes to your deposition below. Be sure to list the page, line, description of change and the reason for your change. Please sign and date when complete. While the changes are not physically made to the transcript, the errata sheet is forwarded to the ordering attorney and will be added as an addendum to your transcript.

PAGE	LINE	DESCRIPTION OF CHANGE	REASON FOR CHANGE
14	11	organization called SEAK	misspelling / clarification
14	17	"	"
20	5	Compliance should be "complaints"	word substitution
58	6	SIRS-2 in place of SIRS 2	misspelling
58	8	"	"
58	9	"	"
58	18	"	"
58	24	"	"
59	12	"	"
59	18	"	"
60	4	"	"
60	12	"	"
61	17	"	"

Signature

10/14/24
Date

AFFIDAVIT

State of Ohio)
) SS:
County of Franklin)

I, LARAE COPLEY, MD, do hereby certify that I have read the foregoing transcript of my testimony given on Friday, September 27, 2024; that together with the correction page attached hereto noting changes in form or substance, if any, it is true and correct.

LARAE COPLEY, MD

I do hereby certify that the foregoing transcript of the deposition of LARAE COPLEY, MD was submitted to the witness for reading and signing; that after she had stated to the undersigned Notary Public that she had read and examined her testimony, she signed the same in my presence on the 14th day of October, 2024.

Notary Public

My commission expires August 16, 2028.

--|--

NOTARY PUBLIC STATE OF OHIO

JENNIFER L SHANKMAN
Notary Public, State of Ohio
My Commission Expires
August 16, 2028

Integrity Reporting Group, Inc.
614.875.5440
IntegrityReportingGroup.com

To: Ms. Abigail F. Chin, abbyc@cooperelliott.com
Ms. Alexandra N. Pickerill, anpickerill@columbus.gov

Date: October 17, 2024

Subject: James A. Burk, Jr., et al. v. City of Columbus, et al.
No.: 2:20-cv-6256
Deposition of: LaRae Copley, MD
Date Taken: September 25, 2024

REPORTER'S SIGNATURE CERTIFICATION

The deposition of the above-referenced witness has been previously transcribed and delivered to counsel who ordered. The witness did not waive signature to the deposition at the time it was taken. Be advised that the witness had been notified that they had a period of thirty (30) days under Ohio Rule 30(E) or thirty (30) days under Federal Rules of Civil Procedure Rule 30(e) to read the deposition and make necessary corrections/changes to the deposition.

_____The witness failed to return an errata sheet and affidavit page within the specified time period which expired on _____. The deposition is now complete as previously transcribed.

__X__The witness has read the deposition and signed the declaration. A copy the notarized errata page is enclosed for counsel.

_____The witness has returned only the signed errata sheet after the 30 days elapsed.

_____The witness has read the deposition and signed the affidavit before a Notary Public. The witness did not return or complete an errata page(s) by 5:00pm _____. A copy of the affidavit is enclosed for counsel.

_____ The witness has read the deposition and signed the affidavit before a Notary Public. Through their attorney's office, the witness confirmed there were no changes and, therefore, did not return or complete an errata page. A copy of the affidavit is enclosed for counsel.

Please append this letter to the deposition so that your record is complete.